EPSDT – Targeted Population

Support Coordination Training

Purpose of the Training:

To establish a uniform training module for the Support Coordination agency's Designated Trainer and supervisors to use in conjunction with the Support Coordination Training Handbook. This training module shall be used:

- For new support coordinators hired to serve the EPDST – Targeted Population. (This shall be included as part of the 16 hours of orientation training)
- As part of the 40 hours of training annually for existing support coordinators
- As reference material for support coordinators and supervisors

Documents Required For Training

- EPSDT – Targeted Population Support Coordination Training Handbook & Appendices
- EPSDT Training Module –
  - Legacy Medicaid Part 1
  - Bayou Health Plans Part 2

An electronic copy of the handbook has been given to each agency. The PowerPoint presentation will be e-mailed to each agency after completion of the training along with clarification of questions and answers. The handbook contains information in more detail than is provided in this presentation.

EPSDT

- ***E***arly and
- ***P***eriodic
- ***S***creening
- ***D***iagnosis and
- ***T***reatment

EPSDT – Targeted Population Support Coordination

- This program was established as a result of a lawsuit (Chisholm v. DHH) to provide Support Coordination to those individuals who have developmental disabilities and/or multiple or chronic medical needs.

Participant Eligibility

- **Individuals on the NOW Request for Services Registry (RFSR) or all EPSDT participants if medically necessary,**

  AND

- **Under the age of 21,**

  AND

- **Are Medicaid Eligible**

Note: Refer to Appendix P in the Training Handbook and Section 5, Page 54 of the Support Coordination Manual for additional criteria.

How to Access Support Coordination

- Individuals on the Registry are notified of the availability of Support Coordination
- If they wish to participate, they are sent a Freedom of Choice (FOC) form to choose a Support Coordination Agency
- Individuals may elect to receive or discontinue these services at any time. To access the services, they may call SRI at 1-800-364-7828 and request Support Coordination for EPSDT

Services Available to EPSDT Support Coordination Participants

- All medically necessary Medicaid services
- Services through the Louisiana Developmental Disabilities services system, administered by Human Services Districts and Authorities
- Services through the school system or in Early Childhood Education programs

Medicaid Services

- For a complete listing of Medicaid services, consult the **Medicaid Services Chart** *(Appendix B),* in the Handbook.
- The EPSDT-Targeted Support Coordination Training Handbook also provides detailed information about specific services.

Other Medicaid Services for Individuals Under Age 21

- Psychological evaluations and therapy
- Psychiatric residential care
- Medical, dental, vision and hearing screenings and care
- Audiology services
- Speech and language evaluations and therapies
- Occupational therapy
- Physical therapy
- Pediatric Day Health Care
- Applied Behavioral Analysis

Other Medicaid Services for Individuals Under Age 21

- Personal Care Services
- Home Health Services
- Extended Home Health Services
- Hearing aids and supplies needed for them
- Eyeglasses and/or contact lenses
- Nutritional supplements needed for growth or nourishment
- Any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice
- Diapers

Note:

- Through Medicaid, *individuals under age 21* are entitled to receive **all medically necessary** health care, diagnostic services and treatment and other measures coverable by Medicaid to correct or improve physical or mental conditions, even if these are not normally covered as part of the state's Medicaid program.

Important Information about Medicaid Services

- No generally fixed limits - Participants under age 21 are entitled to as many doctor visits, and as many hours and amounts of any other services, as are **medically necessary** for their individual conditions.
- More comprehensive than services offered through schools as part of a child's Individualized Educational Plan (IEP) - IEPs only cover services that help with a child's *education*. Medicaid, outside of the IEP process, should cover services needed to help any other aspect of a child's life, as well.
- Some Medicaid services must be **"prior authorized (PA)"** before service can be provided.

EPSDT Screening Exams and Checkups

- Medicaid participants under the age of 21 are eligible for checkups ("EPSDT screening") from physicians.
- These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision, hearing and dental screenings.
- They are available both on a regular basis, and whenever additional medically necessary health treatment or services are needed.
- There are no limits on the number of visits that are **medically necessary** for the individual's condition.

Interperiodic Screen

- An **interperiodic screen** can be obtained whenever one is requested by the parent or recommended by a health, developmental, or educational professional (including a Support Coordinator), who comes into contact with the child outside of the formal health care system in order to determine a child's need for health treatment or additional services.

For Legacy Medicaid: Specialty Care Resource Line 1-877-455-9955

- Support Coordinators can call the Specialty Care Resource Line to find medical providers of various types and specialties for their participants and to help identify needed sources for referrals that may otherwise be difficult to find.
- The Specialty Care Resource Line is supported by an **automated resource directory** of all Medicaid-enrolled providers of medical services, including physicians, dentists, mental health clinics, and many other health care professionals. The database is updated regularly.

Home and Community Based Waivers for persons with developmental disabilities

- New Opportunities Waiver (NOW) – comprehensive home and community based services for individuals 3 years of age or older meeting required medical and financial criteria.
- Supports Waiver – for individuals age 18 or over who meet required medical and financial criteria. Services are specific activity focused rather than continuous custodial care.

HCBS Waivers cont'd

- Residential Options Waiver (ROW) – Offers a choice of expanded home and community based services for individuals of all ages meeting required medical and financial criteria.
- Children's Choice Waiver – a limited package of home and community based services for children under the age of 19 meeting required medical and financial criteria

KNOW THE FACTS about Children's Choice

- Services are capped at $16,410 per year and can be used for medical care, home and vehicle modifications, care-giving assistance and support, and other specialty services.
- Child's name is taken off the Request for Services Registry for the NOW program, but may return under certain circumstances.

How can a Children's Choice recipient get a NOW slot?

1. **When a Children's Choice participant reaches age 19 if it is the appropriate adult waiver.**
2. **If a crisis situation develops,** additional supports may be approved by the Office for Citizens with Developmental Disabilities (OCDD)
3. **If there is change in circumstance** that makes the services under the NOW more helpful to them than services under the Children's Choice Waiver, and the child's date on the RFSR has been passed, the child may obtain the next available waiver slot. This does not require that there has been a change in the recipient's medical condition, but can include loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment.

Children's Choice (continued)

- For more information about the Children's Choice Waiver, refer to Appendix D "Fact Sheet on Children's Choice Waiver" and "Frequently Asked Questions" in the Handbook.

Louisiana Behavioral Health Partnership

The Louisiana Behavioral Health Partnership (LBHP) is the system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services. The LBHP is managed by the Office of Behavioral Health, which oversees the Behavioral Health Statewide Management Organization (SMO), Magellan Health Services of Louisiana. Magellan manages behavioral health services for Medicaid and Non-Medicaid eligible populations including those Medicaid eligible children who will need coordination of services provided by the multiple partner agencies of the LBHP: OBH, Medicaid, Office of Juvenile Justice, Department of Children and Family Services, and Department of Education. The LBHP is designed to serve the needs of individuals who comprise one of the following target populations:

- 1. Children with extensive behavioral health needs either in or at-risk of out-of-home placement;
- 2. Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care;
- 3. Adults with severe mental illness and/or addictive disorders who are Medicaid eligible; and,
- 4. Non-Medicaid children and adults who have severe mental illness and/or addictive disorders.

LBHP Services

Children receiving or eligible for Medicaid can receive these services when medically necessary:

- Psychiatrist
- Psychosocial rehabilitation
- Individual, family, and group therapy
- Substance abuse treatment
- Community-based services
- Residential treatment,
- Emergency room services
- Psychiatric hospital
- Case conference

LBHP Services

- **Behavioral Health Rehabilitation Services** includes Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Crisis Intervention (CI), and Therapeutic Group Home. The Magellan prior authorization unit must approve CPST and PSR services.
- **School-Based Behavioral Health Services**
- **Evidenced Based Practices such as:**
  - **Assertive Community Treatment (ACT)**
  - **Family Functional Therapy**
  - **Multi-systemic therapy**

Refer to Appendix I-1 LBHP Services and Links

Louisiana Behavioral Health Partnership
Coordinated System of Care (C-SoC)

CSoC helps Louisiana's at-risk children and youth who have serious behavioral health challenges and their families. It offers services and supports that help these children and youth return to or remain at home while they are being helped.

The goal of the CSoC is to keep children:

- At home.
- In school.
- Out of child welfare.
- Out of the juvenile justice system.

CSoC

- Anyone can make a referral for CSoC by calling Magellan's care manager at 1-800-424-4399 for brief assessment.
- If the individual screens positive on the brief CANS assessment, Magellan will make a referral to have an independent full CANS assessment conducted by a certified provider who cannot be the treatment provider.
- Parents/caregivers and family members have a key role in CSoC.
- Every youth and family in the CSoC will be enrolled with a Wraparound Agency (WAA) and will work with a wraparound facilitator who coordinates their care. The WAAs develop a single plan of care and provide lots of help for children in the CSoC.
- CSoC also has Family Support Organizations (FSO) to help families. The FSO provides Parent and Youth Support and Training and makes sure families are involved and have a voice in their care.

CSoC

Youth in out-of-home placement or at risk of out-of-home placement and children and youth who are enrolled in the Coordinated System of Care (CSoC) may receive these **additional** services:

- Youth Support and Training
- Parent Support and Training
- Independent Living Skill-Building Services
- Short-Term Respite
- Crisis Stabilization

Personal Care Services

- Tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when cognitive or physical limitations necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.
- PCS **does not include medical tasks** such as medication administration, tracheotomy care, feeding tubes or indwelling catheters. Assistance with these tasks can be covered through Medicaid's Home Health program.
- PCS **is not intended as a substitute for child care needs or to provide respite care to the primary caregiver.**
- A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children.

How do I find a PCS provider?

- A list is available through the Medicaid website at www.dhh.louisiana.gov under Medicaid, Locate a Provider, Personal Care Services, and the region or parish where the participant lives.
- Assistance is also available by calling the Specialty Care Resource Line.

What if a PCS provider is not available?

- If you cannot find a PCS provider from the list of providers on the DHH website, which is willing to submit a prior authorization request, **call the DHH program staff line** at 1-888-758-2220.
- The DHH Headquarters' line hours of operation are 8a.m. – 4:30p.m. with a voice mail message system for overflow and after hour calls.
- **DHH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

What if a PCS provider can't find staff?

- The support coordinator must notify the DHH PAL and DHH Program Staff Line if the provider is unable to find staff after services have been approved. This shall be documented in the case record.
- The support coordinator should assist the family in finding another provider agency with available staff from the DHH website list of providers.
- DHH will take all reasonable and necessary steps to obtain a provider who can staff the approved services within ten days.

How is PCS authorized?

- Personal Care Services must be prior authorized by Molina
- The provider must complete a Social Assessment form, a daily time schedule and develop a plan of care.
- A physician must complete an EPSDT-PCS Form 90 to prescribe or refer the service, and sign the provider's plan of care.
- The number of hours approved is based on assistance with the personal care needs that are covered through this program. There are no set limits to the number of hours a participant can receive.
- The Support Coordinator should assure that the physician has all critical information before the services are prescribed.
- All PA requests should include necessary documentation to support the medical necessity of the request.

Extended Home Health Services

- Skilled nursing services are available for medically necessary home care that requires at least three hours of nursing care per day.
- Home Health agencies can also provide physical, occupational, and speech therapy in the home if this is medically necessary.
- Home Health Services for children and youth are not limited in terms of frequency or duration.
- A physician must order this service, and Extended Home Health Services must also be prior authorized.

EPSDT PCS vs. Home Health Services

Please refer to Appendix E in EPSDT-Targeted Population Support Coordination Training/Handbook

What if a Home Health provider is not available?

- If you cannot find a Home Health provider from the list of providers on the DHH website, which is willing to submit an authorization request (including in-home speech, occupational or physical therapy), call the **DHH program staff line at 1-888-758-2220**.
- The DHH Headquarters' line hours of operation are 8a.m.-4:30p.m. with a voice mail message system for overflow and after hour calls.
- **DHH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

What if a Home Health provider can't find staff?

- The support coordinator must notify the DHH PAL (referral to PAL) if the provider is unable to find staff after the service has been approved. This shall be documented in the case record.
- The support coordinator should assist the family in finding another provider agency with available staff from the DHH website list of providers.

Pediatric Day Health Care

- Serves medically fragile individuals under the age of 21, including technology dependent children, who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition.
- These facilities offer an alternative or supplement to receiving in-home nursing care.
- PDHC may be provided up to seven days per week and up to 12 hours per day as documented by the recipient's Plan of Care.
- Care and services to be provided shall include but shall not be limited to:(a) Nursing care, including but not limited to tracheotomy and suctioning care, medication management, and IV therapy. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with aids of daily living. (e) Transportation services. (f) Education and training.
- Before and after school care is not a covered service because PDHC is designed to be offered for either half a day or a whole day.

Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- For Medicaid to cover these services through a school or in an early childhood educational setting, they must be part of the child's IEP or IFSP.
- For Medicaid to cover the services through a provider outside of an educational setting, they do not need to be part of the IEP or IFSP, but must be prior-authorized by Medicaid.

Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- Therapies can be provided at school, in an early childhood educational setting, in the home, or in a combination of settings.
- The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit making the appropriate referral and coordinating the days and times of this service with other services the participant is receiving.

What if a Physical Therapy or Occupational Therapy provider is not available?

- If you cannot find a Physical Therapy or Occupational Therapy provider from the list of providers on the DHH website, which is willing to submit an authorization request, call the **DHH program staff line at 1-888-758-2220**.
- The DHH Headquarters' line hours of operation are 8a.m.- 4:30p.m. with a voice mail message system for overflow and after hour calls.
- **DHH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

Medical Equipment and Supplies

- Participants are entitled to any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions.
- This includes lifts and other devices to help the family deal with a child's circumstances, and also some medically necessary dietary or nutritional assistance.
- Medical Equipment and Supplies must be prescribed by a physician and prior authorized.

Medical Equip & Supplies cont'd

- Incontinence supplies for children age 4 up to 21
- Based on medical necessity, pull ups, diapers, and liners/guards may be approved. (Appendix R-1)

Medical Equipment and Supplies

- The Medicaid prior authorization unit may approve **less expensive items** that it believes will meet a participant's needs. If so, the notice of denial should identify the items.
  - The participant can accept the less costly item and still appeal the denial of the item originally requested; however, they must not dispose of, destroy, or damage (beyond normal wear and tear) the less expensive item while the appeal is pending
  - You should consult with the participant and the provider to see if the less costly item identified will work, and help the participant decide whether to appeal for the item originally requested.
  - The support coordinator must explain appeal rights to the family and assist in the appeal if the recipient wants that help.

Transportation

- Non-emergency medical transportation (NEMT) is provided for Medicaid recipients to and/or from a provider for a Medicaid covered service. Children under 17 must be accompanied by an attendant.
- Arrangements for non-emergency transportation should be made at least 24-48 hours in advance.

Transportation

- The role of the Support Coordinator is to assist the family in arranging transportation services for the participant. The phone numbers can be found in the Medicaid Services Chart – Appendix B.
- If special problems prevent the regular Medicaid funded transportation service from meeting the participant's needs, the Medicaid program transportation department at 225-342-2604 will assist in accessing transportation.

"Friends and Family" Transportation

- Louisiana Medicaid will allow family members/friends to become Medicaid funded transportation providers for specific family members, through the "Friends and Family" transportation program. The program pays your friend or family member to take you to medical appointments when certain conditions are met. To assist someone you are serving that may benefit from this arrangement call Molina Provider Relations at (800) 473-2783.

Other Medicaid Services Not Listed

Refer to Appendix F for an expanded list of available services. To ask about other available services, contact the Specialty Care Resource Line (toll free) at 1-877-455-9955 or TTY 1-877-544-9544.

Other Medicaid Services Not Listed

Even if a service is not on the Medicaid services chart or available through a referral from the Specialty Care Resource Line, it must still be covered if it is a service permitted by federal Medicaid law and is necessary to correct or ameliorate a physical or mental condition of a recipient who is under age 21. Persons under age 21 are entitled to receive all medically necessary equipment or items that Medicaid can cover. This includes many items that are not covered for adults. These services may be subject to any restrictions allowable under Federal Medicaid law.

Non-Medicaid Services

- Many non-Medicaid sources of services and support are available, such as:
  - OCDD Human Service Districts and Authorities
    - Flexible Family Funds (Cash Subsidy)
    - Community Support Teams
    - Individual and Family Supports
    - Support Coordination

Non-Medicaid Services

- Office of Behavioral Health Services
  - Local Governing Entities –Behavioral Health Clinics
  - CART (child/adolescent response teams)

Non-Medicaid Services

- School and Early Childhood Education services.
- Other community services

Consult your EPSDT Targeted Population Support Coordination Training Handbook for more information

What Happens at Age 21?

- The participant becomes ineligible for some services at age 21, including support coordination, EPSDT Personal Care Services, Extended Home Health Services, incontinence supplies, and other items or services that are not part of Medicaid offerings for adults.
- The support coordinator should be aware of available services and make arrangements to transition the participant to receive all services he or she may need in order to continue to live in the most integrated setting that is appropriate for him.
- The support coordinator should begin making arrangements for transition at least 6 months prior to the participant's 21st birthday

Age 21, cont'd

Available services may include:

- OCDD services, including (in addition to those listed above) extended family living, supported independent living, and vocational and rehabilitative services.
- Medicaid Long Term-Personal Care Services (LT-PCS). Participants who are receiving EPSDT-PCS will be contacted by Xerox regarding LT-PCS. The support coordinator should inform the family to expect notification via phone or mail. Additional information can be obtained about LT-PCS by calling **1-877-456-1146**.
- OAAS- Community Choices Waiver and Adult Day Health Care Waiver services (call 1-877-456-1146 to request to be placed on the Request for Services Registry).
- Louisiana Rehabilitation Service may provide assistance with services needed to pursue short or long-term employment goals.

Medicaid Services Chart

- Medicaid Services Chart *(Appendix B EPSDT Target Population Support Coordination Training/Handbook)*
- *If the Specialty Care Resource Line does not have providers listed, call the contact person listed on the Medicaid Services Chart. Call the DHH Staff Line for providers if the Service contact person is unable to assist at 1-888-758-2220.*

Support Coordinator Responsibility

After linkage is made:

- Validate Medicaid Eligibility through MEVS/REVS or e-MEVS at the beginning of every month
- If the participant becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed (as identified in Appendix U)

Intake

- Contact the participant within 3 working days of linkage
- Determine if the participant is a "competent major." If there is no record of interdiction and the participant is able to express his preferences, the Support Coordinator must speak directly to the participant.
- If the participant has not been interdicted but is unable to express his preferences, the Support Coordinator must document this in the CPOC. (Appendix BB)
- Determine if the participant accepts Support Coordination and agrees with the requirements of the face-to-face visits
- The **Case Management Choice and Release of Information Form (FOC)** can be used to obtain all plans, evaluations, and assessments that OCDD has developed or used in connection with its determination that the participant is eligible for services through the developmental disability services system. The information should be useful in the planning process. (Appendix N)

At the Face to Face Visit

- Inform participants of:
  - Support Coordination Responsibilities
  - Rights & Responsibilities *(Appendix K)*
  - HIPAA & Confidentiality
  - Appeal Process *(Appendix L)*
  - Availability of formal and non-formal services
  - Complaint Process for filing a report against support coordinators and/or Providers *(Complaint Form – Appendix M)*
  - 1-800-660-0488 Health Standards (*Complaint Line*)
  - Review of Medicaid Services Chart *(Appendix B)*

Face to Face cont'd…

- The most current **Medicaid Services Chart** can be found at http://dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

  (Appendix B)

Face to Face cont'd…

- Refer to the Rights and Responsibilities for Participants of EPSDT Targeted population Support Coordination (Appendix K).

  The family is often overwhelmed with everything they are being told in this first meeting. Do not expect the family to remember everything, even if you are providing information in writing.

  REVIEW THIS INFORMATION AS OFTEN AS IS NECESSARY

Assessment

- Is the process of compiling and integrating formal/professional and informal information relevant to the development of a person centered CPOC
- Must begin within 7 calendar days of the referral and complete a face-to-face in home visit within 10 days of the referral

Assessment

- Formal information includes medical, psychological, pharmaceutical, social, educational information, and information from OCDD. Informal information includes information gathered in discussions with the family and participant and may also include information gathered from talking to friends and extended family.
- Assist the participant in arranging professional evaluations and appointments including activating examination/diagnosis/treatment loop such as EPSDT screenings and immunizations and follow-up evaluations

Comprehensive Plan of Care (CPOC)

- The CPOC process uses information from the formal evaluations. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the participant.
- The CPOC is developed through a collaborative process involving the participant, family, friends or other support systems, the support coordinator, and others that know the participant best

CPOC continued

- The CPOC process MUST be completed in a face-to-face meeting with the participant and others they wish to be present
- The CPOC must be outcome oriented, individualized and time limited

CPOC continued

- Must be mutually agreed upon strategies to achieve or maintain the desired outcomes which rely on informal, natural community supports and appropriate formal paid services
- Assist the participant to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes. Use all assessment and intake information to identify the participant's needs

CPOC continued

- Document services the participant is currently receiving
- Explain Medicaid services (using the most current Medicaid Services Chart) with special emphasis on DME, EPSDT, PCS, Home Health and EPSDT Screening Exam. Also available for your use is a PCS and Home Health chart (Appendix E) that will assist in identifying the need for these services.

  Note: PCS can be approved for more than 28 hours per week. The amount of hours approved is based on what is documented as medically necessary and covered through this program.
  *A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children.*
- Identify those additional services that will meet the participant's unmet needs.

Contents of CPOC

Refer to the LSCIS CPOC (Appendix O) for review:

The content of the LSCIS CPOC is the same information that was required in the previous version.

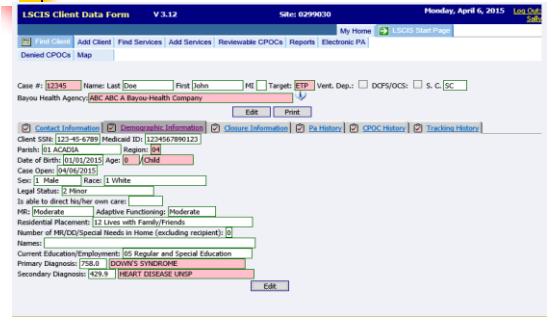
- Section 1 – Demographics/Contact Information
- Section 2 – Medical/Social/Family History
- Section 3 - CPOC Service Needs and Supports
- Section 4 – Additional Information/Participants
- Section 5 – CPOC Approval
- Typical Weekly Schedule (paper form)

Contents of CPOC

Section 1 – Demographics/Contact Information

- Completion of demographics
- Include information about parent or legal guardian and relationship
- Fill in all blanks or provide explanations if information is unknown

LSCIS CPOC Section 1 Demographics/ Contact Information



Contents of CPOC Cont'd…

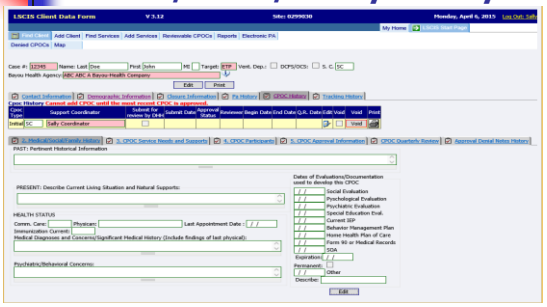
Section 2 – Medical/Social/Family History

- Interview or provide information about as many family members or significant others involved in the participant's life as possible
- Identify strengths and weaknesses of the primary caregiver and informal supports
- Document all information the family is able to identify

Contents of CPOC Cont'd…

- **Section 2 cont'd**
  - If a behavioral support plan is needed as part of the CPOC, make referral for this service. Psychological and behavioral services are available for participants.
  - Identify formal information documents used in assessing needs.
  - If more information is needed to determine the participant's health needs, make referrals for health screenings and help participant access these services.

LSCIS CPOC Section 2 – Medical/Social/Family History



Contents of CPOC Cont'd…

Section 3 - CPOC Service Needs and Supports

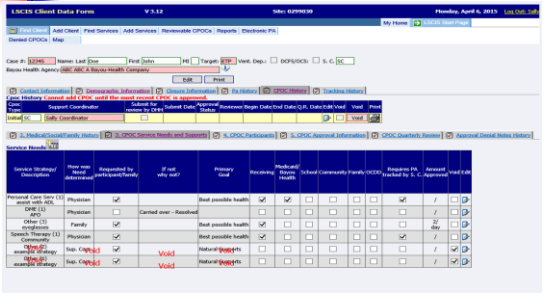
- Identify all goals and the support strategy needed to meet the goals (Who, What, When Where & How Often) Additional space is available in section 4.
- Identify all services the participant is currently receiving (Medicaid and non-Medicaid) and those that will be requested, clearly identifying each and the amounts approved.
- Identify all services that will be coordinated (Medicaid and non-Medicaid)

Contents of CPOC Cont'd…

Section 3 – cont'd

- Identify services for the participant that require prior authorization (PA)
- Assure and document at the time of the CPOC meeting the participant/family understands that services and goals may be added whenever a request is made, if they chose not to access a service when the need is first identified.

LSCIS CPOC Section 3 – CPOC Service Needs and Supports



Contents of CPOC Cont'd…

Section 4 – Additional Information/CPOC Participants

- Document the following occurred:
  - Explanation and review of Medicaid Services Chart
  - The Services Available to Medicaid Eligible Children Under 21 Brochure has been provided (Appendix F)
  - Referral to EPSDT Screening provider
- Identify how often the goals and support strategies will be reviewed (minimum requirement is quarterly).

Contents of CPOC Cont'd…

Section 4– cont'd

- Reminder: Section 4 requires documentation of review of the Medicaid Services Chart; however, the Medicaid Services Chart should also have been reviewed initially during the face to face visit.
- The Medicaid Services Chart should be kept handy and reviewed as many times as necessary during the development of the CPOC.

Contents of CPOC Cont'd…

Section 4– cont'd

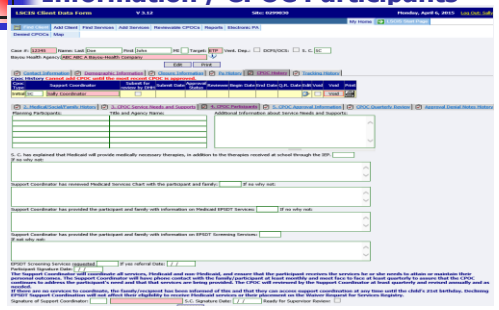
- An Additional Information section is available to address goal strategies if needed and identify all of the service providers.

Contents of CPOC Cont'd…

Section 4– cont'd

- **CPOC Participants**
  - All individuals and providers present at the CPOC meeting must sign the CPOC indicating they participated in the planning
  - The Medicaid EPSDT participant and/or parent/ guardian must sign and date the completed CPOC
  - The support coordinator present at the meeting must sign the CPOC

LSCIS CPOC Section 4 – Additional Information / CPOC Participants



CPOC Approval

Section 5 – CPOC Approval Information

- The support coordinator's supervisor must review the current and prior CPOC, formal information documents, Service Logs, and Quarterly Reviews prior to signing and submitting the CPOC to SRI.
- The Support Coordinator must submit the approvable CPOC to be received by SRI no later than 35 days from the date of linkage/referral.

NOTE: The CPOC will not transmit unless all required fields are completed. The original signature pages must be kept in the case record.

CPOC Approval

Section 5– cont'd

- **For initial plans, assessment data shall be sent via mail or fax. All other information as required on the Checklist for EPSDT Support Coordination Approval Process (Appendix X) shall be kept in the case record at the agency.**
- **The CPOC may be randomly selected for monitoring when the SC supervisor submits it to DHH/SRI for review. The Monitoring Checklist (Appendix X-2) and required documents must be received by SRI within the required timeline.**
- **The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC (date the recipient or parent/guardian signed the approval page) and prior to approval from BHSF/SRI.**
- **Approval of Medicaid state plan services is through the PA unit, therefore, the Support Coordinator should not await BHSF/SRI approval of the CPOC before making referrals for necessary services.**

CPOC Approval

Section 5– cont'd

- BHSF/SRI shall review the CPOC to ensure that all notification, information, planning and identification of needed services has been included
- Any information not completed will result in the CPOC being returned without approval for completion
- Again, the CPOC does not control the services. This process only controls the payment to Support Coordination Agencies

LSCIS CPOC Section 5 – CPOC Approval Information

Contents of CPOC Cont'd…

Typical Weekly Schedule (paper form)

- The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary
- Include all approved services the participant is currently receiving
- Include new services the participant is requesting
- Show when the participant is in school, at home or participating in other activities

Contents of CPOC Cont'd…

Typical Weekly Schedule

- If a prior authorized service is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect only services actually put in place
- If the participant wishes to change any of the times for established services, the support coordinator shall give the revised schedule to all appropriate providers informing them of the time changes
- This document is kept in the case record

Coordination of Services

- Support Coordinator should provide as much assistance as possible to the family to identify and obtain other non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan.
- The CPOC is considered a holistic plan, therefore the Support Coordinator is responsible for coordinating all identified service needs, including paid and un-paid supports as well as non-Medicaid Services.

Coordination of Services

- Support Coordinators should:
  - Give the participant/family a Choice of Providers (unless they are already satisfied with a provider)
  - Give the participant the medical information forms that are required for the specific service. Assist with scheduling the doctor appointment, transportation, etc., as needed.
  - Have the participant/family list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers (Appendix Z)
  - Make referrals to the appropriate providers

Coordination of Services

- Support Coordinators should:
  - Assist the participant in contacting prospective providers and finding out if they are willing to submit prior authorization requests
  - Obtain lists of providers from the Medicaid website and the Specialty Care Resource Line. If none of these providers is able to provide the services, call the DHH Program Staff Line at 1-888-758-2220 to report the difficulty.

Coordination of Services

- Support Coordinators should
  - Assist the family/provider in gathering the appropriate documentation needed to support the request.
  - Notify the PAL if the provider is unable to find staff after the services have been approved.

Coordination of Services

- The support coordinator will immediately begin to coordinate all identified needed services.
  - The Referral to Provider form (BHSF-PF-03-016, Appendix Q) shall be used to make referrals to providers for those services requiring prior authorization.
  - The support coordinator shall document the process using the electronic EPSDT Tracking Log and the electronic EPSDT Service Logs.
  - The process shall begin no later than the CPOC completion date

Coordination of Services

- All services shall be coordinated by the support coordinator
- Any new services identified that require prior authorization will be coordinated. The support coordinator shall make the referral by utilizing the "Referral to Provider Form" (Appendix Q)
- Referral to providers should be made within 3 days of CPOC completion, or within 3 days of the date the family selects the direct service provider as documented on the Choice of Provider Form (if the date of provider selection is later than the CPOC meeting)

Coordination of Services

- All referrals require that you initiate and document all contacts on the electronic EPSDT Prior Authorization Tracking Log and the EPSDT Service Log
- These entries must be up to date as BHSF/SRI and/or Health Standards may request to review this information in order to verify services and prior authorization information

EPSDT Prior Authorization Tracking Log

- The electronic **EPSDT Prior Authorization Tracking Log** is an important tool for Support Coordinators
  - Provides assurance the participant is receiving the services requested (PA should be issued within 60 days of request from date of Choice of Provider)
  - Serve as a reminder to contact the provider if you have not received a copy of the Prior Authorization Request Form
  - Allows you to know at a glance what was/was not approved and the dates

EPSDT Prior Authorization Tracking Log

- Serve as a reminder to notify the provider to submit a prior authorization request to assure continuation of services (45-60 days prior to PA end date)
- Provide documentation that appeal assistance was offered/provided to the participant and the Appeals brochure was provided
- Serve as documentation of the date the prior authorization request was received.

EPSDT Prior Authorization Tracking Log

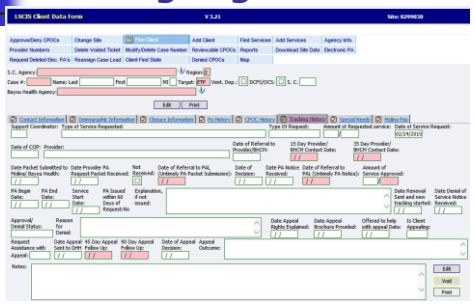
- A separate log is completed for each service that requires prior authorization. (Note: supplies relating to a specific activity may be listed on one log if the provider and PA service dates are the same.)
- A new entry log is used for each PA cycle after the reminder notice for renewals is sent to the provider. (The date the reminder notice is sent is the date of referral for a new tracking log.)
- A new log is used for changes in existing services (i.e., additional hours of service requested).

EPSDT Prior Authorization Tracking Log

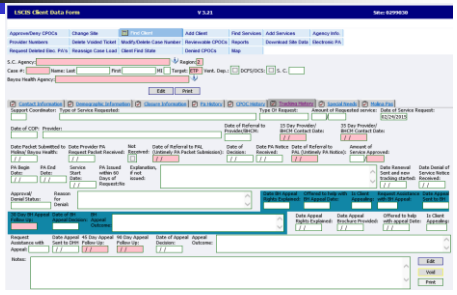
- The log provides space for ongoing tracking information relating to the status of the prior authorization/service
  - Type of Service and Amount
  - Date of Request and Date of COP (Choice of Provider)
  - Provider
  - Date of Referral to Provider (within 3 days of date of COP)
  - Required Provider Contacts
  - Referral to PAL (if required)
  - PA Approval and Dates

NOTE: A new log is to be initiated for each new choice of provider.

LSCIS Prior Authorization Tracking Log



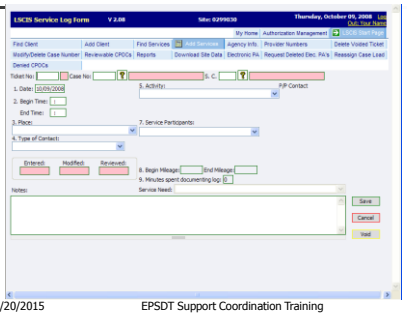
LSCIS Prior Authorization Tracking Log for Bayou Health Services



EPSDT Service Log

- The EPSDT Service Log should be used for documenting activities related to EPSDT services
- A separate service log should be used when possible to document activity related to a specific requested prior authorized service as identified on the EPSDT Prior Authorization Tracking Log.
- All contacts with the Participant, Provider, PAL, and DHH Program Staff Line must be documented including monthly contact with the participant/family to check status of implementation of services
- Document receipt of the approval, denial or reduction of services

LSCIS Service Log



Coordination of Services Cont'd…

- After 15 calendar days from referral, contact the provider to see that they are working on the request and to see if they need any assistance gathering information.
- Within 35 calendar days after referral, you should contact the provider and ask if the request has been submitted to Medicaid or if there were problems that you could assist with.
- If a Prior Authorization packet has not been submitted, use the Referral to PAL form to notify the PAL. Also inform the participant about their right to change providers.

Prior Authorization Liaison

Medicaid Prior Authorization Packet

(Appendix R)

Prior Authorization Liaison

Established to facilitate the PA approval process for Medicaid recipients under age 21 who are part of the NOW Request for Services Registry

Prior Authorization Liaison

- The Chisholm v. Hood lawsuit settlement stipulates that the support coordinator is notified of requests, status, and any delays to the PA approval process.
- The PAL will maintain a tracking system to ensure support coordinators remain aware of the status of PA requests, submission, decision dates and reconsiderations.

Prior Authorization Liaison

PA requests are given to the PAL when the request cannot be approved due to

- Lack of documentation, or
- Technical errors
  - Overlapping dates of service
  - Incorrect procedure codes
  - Prescription not signed by the doctor

Prior Authorization Liaison

- The PAL will attempt to resolve the problem.
- Within 24 hours of the PAL receiving the request, the PAL makes the initial contact by phone or fax to the provider, participant, and support coordinator.

Prior Authorization Liaison

- If the issue is not resolved after 10 days of initial contact with the provider, a Notice of Insufficient Documentation is sent to the provider, recipient and support coordinator advising them of the specific documentation needed.
- The needed documentation must be returned to the PAL within 30 days of the notice date.

Prior Authorization Liaison

Support Coordinator Role

- Communicate promptly with the PAL to facilitate requests for information

Prior Authorization Liaison

- Support Coordinator Role (continued)
  - Track status of requests
    - Advise PAL of providers not actively developing requests
    - Inform recipients of right to choose another provider
    - Assist recipient in locating another provider
  - Communicate with the family and provider and provide assistance in assembling documentary support on prior authorization requests

Prior Authorization Liaison

Support Coordinator Role, Continued

- Follow up so that a PA decision is received, instead of having the service denied due to a lack of information
- If a "Notice of Insufficient Documentation" is received, assist the participant in obtaining documentation. If you are not sure enough additional information is available, help the recipient schedule a doctor's appointment and return the second page of the Notice filled in with the date of the appointment to the PAL.
- If a PAL referral is done, notify them of any scheduled doctor appointments.

Prior Authorization Liaison

- Contacts
  - **Molina PAL**

Danielle Smith
1-800-807-1320 option #2
Fax: 225-216-6478
Molina Healthcare
Prior Authorization Liaison
P. O. Box 14919
Baton Rouge, LA 70898-4919

  - **Medicaid PAL**

Linda Smith
linda.smith@la.gov
(225) 342-6711
Fax: (225) 389-2749 or
1-877-747-0997

  - **BH Rehab. PAL (Office of Behavioral Health)**

Margaret Hubbard
margaret.hubbard@la.gov
(225) 342-1075
Fax: (225) 342-0001

Prior Authorization Liaison Bayou Health Plans

- **Aetna**

  Tiffany Estopinal, PAL
  504-667-4463 / Fax: 844-227-9205
  EstopinalT@aetna.com

  Tricha Arabie
  504-667-4058 / Fax: 844-227-9205
  ArabieT@aetna.com

- **Amerigroup**

  Viince Piazza, RN – PAL
  504-834-1271 ext. 88784
  vince.piazza@amerigroup.com

  Marcia Oliva, Med Mgt Specialist II - PAL
  504-834-1271 ext. 88793
  Marcia.oliva@amerigroup.com

- **AmeriHealth Caritas of Louisiana**

  Lana Nugent, RN Care Manager – PAL
  225-300-9087 / Fax: 225-757-8629
  lnugent@amerihealthcaritasla.com

  Jamie Meister, RN Care Manager PAL
  225-300-9125
  jameister@amerihealthcartasla.com

- **Louisiana Healthcare Connections**

  Nyga Hinton, PAL
  866-595-8133 ext. 69580
  nhinton@centene.com

- **UnitedHealthcare**

  Kathy Zamarron, PAL
  832-500-6751 / Fax: 866-895-3334
  Kathy_L_Zamarron@uhc.com

  Sara Davis, PAL
  832-500-6691 / Fax: 855-416-7621
  Sara_E_Davis@uhc.com

Prior Authorization Liaison

Refer to Appendix R for a copy of the PAL notices.

Prior Authorization Liaison

To summarize the PAL and Support Coordinator's roles:

- If additional information is needed to process the request, the PAL will contact the provider, participant, and support coordinator within 24 hours.
- The support coordinator is to assist in obtaining the additional information. This will not supplant the responsibilities of the provider.
- The support coordinator will receive a copy of all notices (i.e. approved, denied, reduction in services and request for additional information) regarding the requested service.

Coordination of Services

- **Follow-up shall be made with the participant as needed and at least monthly to ensure that all services identified on the CPOC have been implemented and he/she is receiving services in the amount approved and at the times requested**. (If the participant is not satisfied, the support coordinator shall follow-up with the provider. If it cannot be resolved, the support coordinator will forward a report to the PAL using the Referral to the PAL Form – BHSF-PF-03-015, Appendix S)
- **You must report to BHSF ALL services where a decision was not made within 60 days from the completion of the CPOC or from the FOC date. When a new provider is chosen, the 60 days do not start over and these instances shall be included in the reporting**.

Coordination of Services Cont'd…

- If the approved services are different than those designated on the CPOC Typical Weekly Schedule, the schedule must be revised to reflect the actual approved services/schedule using the legally accepted correction procedure. The schedule change does not have to be sent to SRI at this time.
- You only need to contact previously approved providers if the participant wants a scheduling change

Coordination of Services – Renewals of Prior Authorization

The provider must submit the packet no less than 25 days prior to expiration of the prior authorization for services to continue without interruption. Some services may not require a full prior authorization packet.

- The Support Coordinator must send a reminder letter (Referral to Provider form – BHSF-PF-03-016, Appendix Q) to the provider no less than 45 or more than 60 calendar days prior to the expiration of the prior authorization.

Coordination of Services Cont'd… APPEALS/Reduction in service requests

The support coordinator must inform the participant of his/her Appeal rights and provide the Appeals Brochure. The appeals brochure is located on the internet at http://new.dhh.louisiana.gov/index.cfm/page/323

- Refer to the Appeals Brochure (Appendix L) – for Legacy Medicaid and for Bayou Health after they have exhausted the Bayou Health appeal
- Review the brochure in its entirety
- Explain that the recipients can receive the services or items that have been approved, and appeal for whatever was denied. They do not need to choose between filing an appeal and receiving the approved services.

Coordination of Services Cont'd… APPEALS/Reduction in service requests

- The support coordinator must ask the participant/family if they need/want assistance with filing the appeal
- The support coordinator must assist with an appeal if assistance is wanted by the recipient. Review the Appeals section of the EPSDT SC Training Handbook.
- Regardless of whether or not the support coordinator is assisting with the appeal, they must follow-up with the participant within 45 calendar days of the appeal request to see if they have received a response, and/or need additional assistance.

Coordination of Services Cont'd… APPEALS/Reduction in service requests

- The support coordinator should follow-up again with the participant at least 90 days after the appeal was sent to check on the final decision regarding the appeal.
- Document all information on the electronic EPSDT Prior Authorization Tracking Log and EPSDT Service Log (LSCIS)

Follow-up Requirements

- After the CPOC meeting there must be a contact at least monthly and as needed to:
  - Assure implementation of requested services.
  - Determine service start date after the PA is received.
  - Assist, as requested, with identified needs and problems with providers.
  - Follow up on obtaining information to complete a PA request.
  - Offer to assist with an appeal.

Follow-up Requirements Cont'd

- There must be a face-to-face contact at least quarterly to identify:
  - Service needs and status through review of the CPOC
  - Completion of the EPSDT Quarterly Review/ Checklist and Progress Summary (LSCIS) Note: The original signature page must be kept in the case record.

Follow-up Requirements Cont'd...

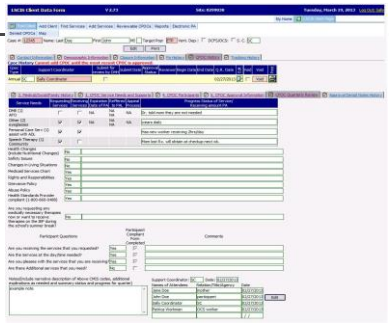
  - Additional services requested
  - Scheduling issues (update the Typical Weekly Schedule)

- Note the face-to-face quarterly visit does not have to be completed in the participant's home

Follow-up Requirements Cont'd…

- Service delivery issues use the Referral to PAL (BHSF-PF-03-015, Appendix S)
- Any complaints that need to be made (BHSF-RF-03-010, Appendix M)

LSCIS CPOC Quarterly Review



CPOC Revisions

- When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment, the CPOC should be updated in LSCIS. Goals and objectives should be added and/or revised according to the most recent information available. The Typical Weekly Schedule should be revised to reflect the changes.
- A list of participants that have a revised/updated CPOC must be submitted to SRI by the last day of the quarter for each quarter that changes are made to the CPOC.

Follow-up Requirements Cont'd… Forms

- The CPOC including the Typical Weekly Schedule must be revised to reflect any changes in status or information and for the addition of new services or changes in existing services.
- Provider Referral form (BHSF-PF-03-016) shall be used when referring the participant for services, reminding the provider of the renewal date or changing the schedule.
- EPSDT Prior Authorization Tracking Log (LSCIS) and the EPSDT Service Log (LSCIS) must be used to document the process of all initial services, renewals, and appeals.

Follow-up Requirements Cont'd… Forms

- Referral to the PAL (BHSF-PF-03-015, Appendix S) shall be used to identify any problems with the provider
- Participant Complaint Form (BHSF-RF-03-010, Appendix M) shall be used as needed by the Participant
- EPSDT Quarterly Review/Checklist and Progress Summary (LSCIS) is required to be completed at least quarterly. The original signature pages must be kept in the case record
- EPSDT Quarterly Report
- Record Review for the Quarterly Report (Appendix W-1)

Follow-up Requirements Cont'd… EPSDT Quarterly Report

- The EPSDT Quarterly Report will be completed using information entered into LSCIS by the Support Coordination agency.
- The support coordination agency must have all required information entered into LSCIS at the end of each quarter so that the report can be generated.

EPSDT Quarterly Report Cont'd…

- The report will include the names of the participants and the services for the following:
  - Participants whose request for services did not result in a PA being issued within 60 days
  - Participants with gaps in the authorization period
  - Participants who submitted requests for appeals within the quarter

EPSDT Quarterly Report Cont'd…

BHSF/SRI and the DHH attorney will review the information to assure that the participants are receiving the services they need and the assistance they need to access the services. BHSF/SRI will review the PA Tracking and Services Logs and may request additional documentation and information from the support coordination agencies.

EPSDT Quarterly Report Cont'd…

- Referring to the 6/28/06 Memo (BHSF-EPSDT-06-002), It is the responsibility of the SC Agency to identify participants with a prior authorization (PA) not issued within 60 days of the participant's request.
- As part of that identification, the SC Agency must review all documentation (CPOC, Prior Authorization Tracking Log, Service Event list, etc) prior to end of each Quarter.

Requirements for Support Coordination Agencies

- All Support Coordinators must receive EPSDT training
  - New support coordinators and trainees must receive the EPSDT training
    - During orientation and prior to being assigned an EPSDT caseload
    - Must be included as part of the required 16 hours of orientation training
  - All support coordinators and trainees must complete the EPSDT training each year

    The agency's Designated Trainer and Supervisors (Train the Trainer) will be responsible for training the staff.

Requirements for Support Coordination Agencies

All EPSDT Designated Trainers and Support Coordinators Supervisors must receive EPSDT training.

- New Designated Trainers and Supervisors must receive the EPSDT training prior to beginning supervision of EPSDT support coordinators. The training may be provided by BHSF/SRI or by a trained supervisor or designated trainer within the agency.

Requirements for Support Coordination Agencies

- The agency must submit documentation of the training to the EPSDT Program Manager.
- Documentation of annual training must be submitted one time each year.
- Documentation of training for new staff must be submitted by the last day of each quarter, if applicable for that quarter.

Requirements for Support Coordination Agencies

- LSCIS Reports

  The On-Site Manager is responsible for assuring compliance with all program requirements and the EPSDT Specialist is to monitor that all EPSDT requirements are met. They shall check the LSCIS reports at least semiweekly. All deficiencies are to be addressed and resolved.

REMINDERS…

- The purpose of Support Coordination is to coordinate all services and to ensure the participant receives the services he/she needs
- If at any time a provider is not actively working on behalf of the participant, contact the PAL
- Contact SRI if you have questions or your BHSF State Office regarding policy.

EPSDT – Targeted Population

Support Coordination Training
Part 2
Bayou Health Plans

Purpose of the Training:

To provide an overview of Bayou Health for the Support Coordination agency's Designated Trainers and supervisors to use in conjunction with the Support Coordination Training Handbook and Bayou Health related appendices.

Chisholm Members in Bayou Health

- Chisholm Class Members (CCM) enrolled in Bayou Health as of April 1, 2015= 282
- CCM enrolled in Bayou Health receiving support coordination as of April 1, 2015= 18

What is Bayou Health?

- Managed care system for physical health and basic behavioral health
- Covers 950,000 Louisianans
- Five managed care organizations (MCOs) working statewide
  - Aetna
  - Amerigroup
  - Amerihealth Caritas
  - Louisiana Healthcare Connections
  - United Healthcare Community Plan
- February 1, 2015 Chisholm Class Members were able to enroll.

Chisholm Class Members in Bayou Health

- Voluntary Opt-In population
  - May enroll in Bayou Health at any time.
  - May disenroll from Bayou Health at anytime effective the earliest possible month that the action can be administratively taken.
  - Members who have previously disenrolled from Bayou Health may reenroll in Bayou Health only during the annual open enrollment period effective the earliest month that the action can be administratively taken.
  - Members have until the 2nd to last business day of the month to enroll/disenroll with Bayou Health for the effective date to be the first of following month.

Examples

Enrollment:

- CCM calls Bayou Health to enroll on April 8th, the effective date of enrollment for the health plan of choice will be May 1st.
- CCM calls Bayou health to disenroll on April 8th, the effective date of enrollment back into Legacy Medicaid will be May 1st.

Cut Off:

- CCM calls Bayou Health on April 30th to enroll in Bayou Health, the effective date of enrollment will be June 1st.
- CCM calls Bayou Health on April 29th to enroll, their effective date will be May 1st.

Switching Plans

- Chisholm Class Members (CCM) can call Bayou Health at 1-855-229-6848, TTY: 1-855-526-3346 or go online at www.BayouHealth.com to enroll or dis-enroll.
- CCMs have a 90 day choice period during which they can change MCOs for any reason.
- After 90 days, CCMs will be locked in to the MCO for 12 months from the effective date of enrollment or until the next annual open enrollment, unless they opt out of Bayou Health or show cause for disenrollment from the MCO.

Bayou Health Excluded Services

Services Excluded from Bayou Health

- Applied Behavioral Analysis
- Medical Dental
- ICF/DD Services
- Nursing Facility Services
- Individualized Education Plan (IEP) Services
- All Home and Community-Based Waiver Services
- Specialized Behavioral Health Services
- Targeted Case Management Services
- Services provided through DHH's Early-Steps Program
- Long-Term Personal Care Services (for adults)

Excluded Services

- Bayou Health members may obtain the excluded services under the Louisiana State Plan; however, Molina will pay for these services, not the Managed Care Organizations (MCO). The MCOs are responsible for informing members how to access excluded services and assisting in the coordination of these services.
- The Support Coordinator should reach out to the MCO Case Management for assistance with obtaining excluded services.

Value Added Benefits

Value Added Benefits

- MCOs offer value added benefits to their members which are currently non-covered services by the Louisiana Medicaid State Plan.
- A complete listing of each MCO's value added benefits can be found at www.BayouHealth.com by clicking on Comparing Health Plans and Extra Services.

Value Added Benefits (cont.)

- Examples of Value Added Benefits Include:
  - Gift cards that can be used to purchase health related items.
  - Free Boy or Girl Scout annual membership
  - Free Cell Phones
  - Weight management programs

Bayou Health Support Coordination Role

Selecting a Plan

- Support Coordinators should assist CCMs with selecting a Bayou Health plan by providing information on all 5 plans.
- Support Coordinators should ensure that the CCMs providers are in network and that the medications that they are currently prescribed are covered by the health plan's formulary.
- Support Coordinators can use the Bayou Health Plans Comparison chart to assist the CCM with their selection.
- Chisholm Class Members (CCM) can call Bayou Health at 1-855-229-6848 to enroll or go online at www.BayouHealth.com.

What the CCM should expect after enrolling in Bayou Health

- Within 10 days of a member enrolling in Bayou Health, the MCO will send the member a Welcome Packet including their Member ID Card, Member Handbook and Welcome Letter highlighting the MCOs program features.
- Within 14 days of sending the Welcome Packet the MCO will call new members.
- Support Coordinators should familiarize themselves with the Member Handbooks for each MCO.

Member Handbooks Online

- Aetna: http://www.aetnabetterhealth.com/louisiana/assets/pdf/members/MemberHandbook-Eng-LA.pdf
- AmeriHealth Caritas: http://www.amerihealthcaritasla.com/pdf/member/handbook/english.pdf
- Amerigroup: https://www.myamerigroup.com/Documents/LALA_CAID_MHB_ENG.pdf
- Louisiana Healthcare Connections: http://www.louisianahealthconnect.com/files/2011/11/Member-Handbook.pdf
- United Healthcare Community Plan: http://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/LA-UHCCommunityPlan-Member-Handbook.pdf

Accessing Services

- Support Coordinators should utilize the Bayou Health Services Appendix A and B to contact the MCO to determine how the CCM can access specific services. This process may vary for each MCO.
- Support Coordinators are responsible for assisting the CCM with obtaining the documentation including prescriptions for requesting prior authorization of medically necessary services.
- Support Coordinators should also coordinate assistance with Bayou Health Case Management, Bayou Health Prior Authorization Liaison and the Medicaid PAL via phone, email, fax or referral form.

Locating Providers

- Support Coordinators should assist the CCM with locating a provider contracted with their Bayou Health Plan.
- Resources for locating providers include:
  - Online Provider Directory at www.BayouHealth.com
  - Call the Member Services Line at each Bayou Health Plan to locate a provider in their network.
  - Access MCOs' websites to identify contracted providers

Member Services Numbers

- Aetna Better Health
  - 1-855-242-0802
- Amerigroup
  - 1-800-600-4441
- AmeriHealth Caritas
  - 1-888-756-0004
- Louisiana Healthcare Connections
  - 1-866-595-8133
- United Healthcare Community Plan
  - 1-866-675-1607

What if a provider is not available?

- If you cannot find a provider from the Bayou Health website, or the provider directory, which is willing to submit a prior authorization request, call the MCO's member services line which operates from 7am-7pm, M-F , for assistance.
- Support Coordinators should fax the Referral to Bayou Health Case Management form to the MCO to request assistance with locating a provider.
- If the MCO is unable to locate a willing provider within 10 days, the Support Coordinator should submit a referral to the DHH Medicaid PAL

Continuation of Services

- Support Coordinators are responsible for informing the CCM of the MCOs contractual obligation to ensure Transition of Care when enrolling in or switching Bayou Health Plans.
- MCOs Transition of Care Responsibilities
  - MCOs do not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider. However, the MCO may require prior authorization of services beyond 30 calendar days.
  - The MCO will honor any active prior authorization up to 30 days or until the transition of care is complete whether or not the authorization is with a in-network or out-of-network provider.

Switching providers

- Support Coordinators are responsible for assisting CCMs with switching service providers.
- Support Coordinators should send a Referral to Bayou Health Case Management form to inform the MCO of the member's desire to change providers.
- Members have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a member elects to change providers within an authorization period, the current agency must notify the Bayou Health Plan of the member's discharge, and the new agency must obtain their own authorization through the usual authorization process.

Communication

- Support Coordinators should send referral to Bayou Health Case Management once a CCM selects a provider.
- Support Coordinators should maintain communication with Bayou Case Management through submission of the PA and the final determination.
- If the service authorization is denied, the support coordinator should assist the CCM with obtaining the required documentation and ensuring that the documents are submitted to the MCO.
- Support Coordinators should assist the CCM throughout the appeal process, if they choose to appeal.
- Support Coordinators should send referrals to Bayou Health Case Management to inform them of expiring service authorizations.

Communication cont'd…

- Support Coordinators should send a referral to Bayou Health Case Management if:
  - a referral for a service is needed.
  - a provider cannot be located to submit a request for prior authorization for services.
  - a CCM selects a new provider.
  - a CCM wants to choose a new provider.
  - a CCM is requesting a change in schedule.
  - a prior authorization is about to expire.

Communication cont'd

Support Coordinators should send referrals to the Medicaid Prior Authorization Liaison if:

- The SC has not received an approval within 60 days from the Choice of Provider date.
- The participant has been advised of their right to choose another provider and the SC is beginning the process again.

Communication cont'd…

- The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.
- The SC has not received a notice of approval for the renewal approval and the previous PA expired.
- The provider is not providing services at the times the participant requested and the SC has been unable to resolve the issue.
- The provider is not providing the amount of services as per the CPOC and as prior authorized and the SC has been unable to resolve the issue.

Questions and Answers

- All questions should be filtered through SRI to forward to DHH.
- Issues with the communication process should be shared with DHH as well.
- MCO staff members are here today to answer some of your questions.

BAYOU HEALTH APPENDICES

- MCO Contacts for Support Coordinators (Bayou Health A)
- Bayou Health Services - Links and Phone Numbers (Bayou Health B)
- Change in PCS provider during PA period (Bayou Health C)
- Bayou Health PCS and EHH PA Time frames (Bayou Health D)
- MCO PAL Flowchart (Bayou Health E)
- Bayou Health Appeals Timelines and Documentation (Bayou Health F)
- Bayou Health Plans Comparison Chart (Bayou Health G)
- Referral to Bayou Health Case Management (Bayou Health Q)
- Bayou Health Referral to PAL (Bayou Health S)
- Bayou Health EPSDT Timelines & Documentation - Participant (BH T-1)
- Bayou Health EPSDT Timelines & Documentation – Provider (BH T-2)
- Bayou Health EPSDT Timelines and Documentation – PAL (BH T-3)